		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027078

Facility Name: Park Lawn Center

Address: 5831 W. 115th St. (Number) Alsip (City) 60803 (Zip Code)

County: Cook

Telephone Number: (708) 396-1117 **Fax #** (708) 396-1186

IDPA ID Number: 36-2806708

Date of Initial License for Current Owners: 9-22-82

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Janice Leise **Telephone Number:** (708) 425-3344 Ext. 242

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7-1-03 to 6-30-04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 10-28-04 (Date)
(Type or Print Name) James R. Weise
(Title) Executive Director

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	41	Intermediate/DD	41	15,006	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	41	TOTALS	41	15,006	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	14,532			14,532	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,532			14,532	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.84%

D. How many bed-hold days during this year were paid by Public Aid?
327 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/22/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/22/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	74,527	951	4,620	80,098		80,098		80,098			1
2	Food Purchase		113,938		113,938		113,938		113,938			2
3	Housekeeping	53,126	5,318		58,444		58,444		58,444			3
4	Laundry	17,516	6,389		23,905		23,905		23,905			4
5	Heat and Other Utilities			42,923	42,923		42,923		42,923			5
6	Maintenance	42,512	26,326	10,389	79,227		79,227		79,227			6
7	Other (specify):* Waste Rem. Plant Sec		28,520		28,520		28,520		28,520			7
8	**TOTAL General Services**	187,681	181,442	57,932	427,055		427,055		427,055			8
	B. Health Care and Programs											
9	Medical Director			5,538	5,538		5,538		5,538			9
10	Nursing and Medical Records	168,857	28,932	70,496	268,285		268,285		268,285			10
10a	Therapy			2,415	2,415		2,415		2,415			10a
11	Activities		1,555		1,555		1,555		1,555			11
12	Social Services	7,678			7,678		7,678		7,678			12
13	Nurse Aide Training											13
14	Program Transportation	17,084	8,978	4,770	30,832		30,832		30,832			14
15	Other (specify):* QMRP, Hab, Psy, Tr	727,797		1,633	729,430	(1,633)	727,797		727,797			15
16	**TOTAL Health Care and Programs**	921,416	39,465	84,852	1,045,733	(1,633)	1,044,100		1,044,100			16
	C. General Administration											
17	Administrative	49,286			49,286		49,286		49,286			17
18	Directors Fees											18
19	Professional Services			14,811	14,811		14,811		14,811			19
20	Dues, Fees, Subscriptions & Promotions			14,580	14,580	294	14,874	(50)	14,824			20
21	Clerical & General Office Expenses	163,932	24,599		188,531		188,531		188,531			21
22	Employee Benefits & Payroll Taxes			226,614	226,614		226,614	(1,275)	225,339			22
23	Inservice Training & Education			1,981	1,981	1,339	3,320		3,320			23
24	Travel and Seminar			98	98		98		98			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,265	21,265		21,265		21,265			26
27	Other (specify):*											27
28	**TOTAL General Administration**	213,218	24,599	279,349	517,166	1,633	518,799	(1,325)	517,474			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,322,315	245,506	422,133	1,989,954		1,989,954	(1,325)	1,988,629			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park Lawn Center #0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,297	7,297	(4,396)	2,901	29,884	32,785			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,729	2,729		2,729	484	3,213			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			132,911	132,911		132,911	(132,911)				34
35	Rent-Equipment & Vehicles			12,942	12,942		12,942	(4,166)	8,776			35
36	Other (specify):* Unallowed Dep Acq Grant					4,396	4,396		4,396			36
37	TOTAL Ownership			155,879	155,879		155,879	(106,709)	49,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,620	124,620		124,620		124,620			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			124,620	124,620		124,620		124,620			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,322,315	245,506	702,632	2,270,453		2,270,453	(108,034)	2,162,419			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(1,275)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,325)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(106,709)	5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (106,709)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (108,034)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Park Lawn Center

ID# **0027078**

Report Period Beginning: **7-1-03**

Ending: **6-30-04**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Depreciation from Related Party	$ 29,884	30	1
2	Allowable Interest from Related Party	484	32	2
3	Rent- Facility & Grounds	(132,911)	34	3
4	Rent - Equipment & Vehicles	(4,166)	35	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(106,709)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Park Lawn Center **#** 0027078 **Report Period Beginning:** 7-1-03 **Ending:** 6-30-04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(50)	0	0	0	0	0	0	0	0	0	0	(50)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(1,275)	0	0	0	0	0	0	0	0	0	0	(1,275)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,325)	0	0	0	0	0	0	0	0	0	0	(1,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,325)	0	0	0	0	0	0	0	0	0	0	(1,325)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Park Lawn Center **#** 0027078 **Report Period Beginning:** 7-1-03 **Ending:** 6-30-04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	29,884	0	0	0	0	0	0	0	0	0	0	29,884	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	484	0	0	0	0	0	0	0	0	0	0	484	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(132,911)	0	0	0	0	0	0	0	0	0	0	(132,911)	34
35	Rent-Equipment & Vehicles	(4,166)	0	0	0	0	0	0	0	0	0	0	(4,166)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(106,709)	0	0	0	0	0	0	0	0	0	0	(106,709)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(108,034)	0	0	0	0	0	0	0	0	0	0	(108,034)	45

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Park Lawn Assoc.	Oak Lawn	Support Organizatic

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Park Lawn Association, Inc. See explanation on page 5A	N/A	$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Central Office - 10833 S. Laporte Avenue occupies 1717 square feet Administration				$	$		$	1
2		and Accounting and Bookkeeping. This is 6.96% of Total Square footage 24,693.								2
3										3
4		These cost are distributed to each program on the percentage of budget.								4
5										5
6		The Administrative salaries are distributed on the percentage of budget basis.								6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Hinsdale Bank			2002 Mercury Sable	$294.71	01/01/03	$ 20,662	$ 15,047	01/01/08	5.5000	$ 942	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$294.71		$ 20,662	$ 15,047			$ 942	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,662	$ 15,047			$ 942	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003		12

Not Applicable

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Lawn Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027078

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Not Applicable	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: Completely Amoritized 6-30-88 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facilities	124,955	1981	$ 190,000	1
2					2
3	TOTALS	124,955		$ 190,000	3

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	41		1982		$ 210,000	$ 6,000	35	$ 6,000	$	$ 130,636	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing, Heat & AC			1982	165,500	4,729	35	4,729			9
10	Electric & Fixtures			1982	81,400	2,326	35	2,326			10
11	Elevator			1982	33,385	954	35	954			11
12	Concrete			1982	43,171	1,233	35	1,233			12
13	Sprinklers			1982	22,085	631	35	631			13
14	Bath. Access.			1982	2,450	70	35	70			14
15	Construction Int			1982	18,357	525	35	525		369,162	15
16	Carpentry			1982	23,800	680	35	680			16
17	Windows			1982	33,088	945	35	945			17
18	Ceramic Tile			1982	10,621	303	35	303			18
19	Painting			1982	10,166	290	35	290			19
20	Various Construction Materials			1982	75,966	2,170	35	2,170			20
21	Permits			1982	1,803	52	35	52			21
22	Architech Fee			1982	29,577	844	35	844			22
23	Construction Manager			1982	40,000	1,143	35	1,143			23
24	Demolition			1982	6,858	196	35	196			24
25	Windows			1983	4,258	171	25	171		3,580	25
26	Sewer & Sump Pump			1983	4,933		10			4,933	26
27	Humidifer			1985	2,850		10			2,850	27
28	Parking Lot Paving			1983	700		15			700	28
29	Windows			1986	850	34	25	34		620	29
30	Generator			1986	15,785	789	20	789		14,608	30
31	Paving			1986	5,150		5			5,150	31
32	Fence/Gate			1993	2,053		10			2,053	32
33	Armstrong Floor			1994	11,000	367	10	367		11,000	33
34	Roof Repair			1997	26,382	1,759	15	1,759		13,925	34
35	Tile, Main Area, Floor Patch			2001	5,857	586	10	586		1,611	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 888,045	$ 26,797		$ 26,797	$	$ 560,828	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 42,983	$ 3,615	$ 3,615	$	Various	$ 15,564	71
72	Current Year Purchases	1,820	152	152		7	152	72
73	Fully Depreciated Assets	132,583					132,583	73
74								74
75	TOTALS	$ 177,386	$ 3,767	$ 3,767	$		$ 148,299	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See attached Listing on page 24. Small % of many vehicles			$	$	$	$		$	76
77	are used for program.			430,203	2,221	2,221		5	319,704	77
78										78
79										79
80	TOTALS			$ 430,203	$ 2,221	$ 2,221	$		$ 319,704	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,685,634	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,785	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,785	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,028,831	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/03
Ending 06/30/04

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	06/30/2005	$ 129,749
13.	06/30/2006	$ 129,749
14.	06-30/2007	$ 129,749

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See attached listing page 25		$ 210.70	$ 2,528	17
18					18
19					19
20					20
21	TOTAL		$ 210.70	$ 2,528	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 90 OTJ

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Not Applicable	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Park Lawn Center # 0027078 **Report Period Beginning:** 7-1-03 **Ending:** 6-30-04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6-30-04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 546,803	1
2	Cash-Patient Deposits		30,154	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,146	5
6	Prepaid Insurance		44,840	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		467,147	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 1,091,090	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		506,159	16
17	Accumulated Depreciation (book methods)		(363,531)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 142,628	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 1,233,718	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 310,055	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		30,154	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		275,657	30
31	Accrued Taxes Payable (excluding real estate taxes)		4,555	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Reserves		6,728	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 627,149	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Equipment & Lease Fees		515,551	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 515,551	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 1,142,700	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 91,018	$ 91,018	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 91,018	$ 1,233,718	48

***(See instructions.)**

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,902	1
2	Restatements (describe):		2
3	**Net Income FY02-03 inadvertantly omitted**	27,002	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 31,904	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	28,873	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Unallowed Depreciation of Acq. Grant**	(4,396)	15
16	Other (describe) **Net Income Other Programs**	34,637	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 59,114	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 91,018	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,234,073	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,234,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	44,201	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,201	23
	D. Non-Operating Revenue		
24	Contributions	21,052	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,052	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,299,326	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	427,055	31
32	Health Care	1,045,733	32
33	General Administration	517,166	33
	B. Capital Expense		
34	Ownership	155,879	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	124,620	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,270,453	40
41	**Income before Income Taxes (line 30 minus line 40)****	28,873	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 28,873	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,480	1,872	$ 49,445	$ 26.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,386	5,386	102,332	19.00	3
4	Licensed Practical Nurses	1,005	1,005	17,080	17.00	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	307	307	7,678	25.01	11
12	Dietician					12
13	Food Service Supervisor	1,675	1,919	27,649	14.41	13
14	Head Cook	1,493	1,580	18,175	11.50	14
15	Cook Helpers/Assistants	3,504	3,588	28,703	8.00	15
16	Dishwashers					16
17	Maintenance Workers	2,446	2,896	42,512	14.68	17
18	Housekeepers	4,002	4,446	53,126	11.95	18
19	Laundry	1,992	2,189	17,516	8.00	19
20	Administrator	1,004	1,232	49,286	40.00	20
21	Assistant Administrator					21
22	Other Administrative	5,783	6,425	115,860	18.03	22
23	Office Manager	1,776	1,995	35,268	17.68	23
24	Clerical	1,000	1,113	12,804	11.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,240	6,714	83,928	12.50	28
29	Resident Services Coordinator	888	1,035	26,827	25.92	29
30	Habilitation Aides (DD Homes)	63,040	69,185	605,367	8.75	30
31	Medical Records					31
32	Other Health Ca Psych	64	64	4,957	77.45	32
33	Other(specify) Driver/Trainer	1,605	2,162	23,802	11.01	33
34	TOTAL (lines 1 - 33)	104,690	115,113	$ 1,322,315 *	$ 11.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	231	$ 4,620	1-3	35
36	Medical Director	44	5,538	9-3	36
37	Medical Records Consultant	18	630	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	120	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	42	2,115	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	12	1,775	10-3	46
47	P/R, Data Processings, Audit		15,017	19-3	47
48	Legal		172	19-3	48
49	TOTAL (lines 35 - 48)	359	$ 29,987		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	720	$ 33,846	10-3	50
51	Licensed Practical Nurses	975	34,125	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,695	$ 67,971		53

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Weise	Executive Dir.		$ 34,978
Julia Grounds	Deputy Exec Dir.		14,308
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,286

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cocalas, Westberg, Mommsen	Audit	$ 3,533
ADP	Payroll	6,581
James Himmel	Legal	162
Cipher	Data Processing	4,535
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,811

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,865
Unemployment Compensation Insurance	21,413
FICA Taxes	98,895
Employee Health Insurance	73,731
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer Match TSA	3,435
Man Ben $1,275 not included in total	
TOTAL (agree to Schedule V, line 22, col.8)	$ 225,339

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	7,089
Health Care Worker Background Check	220
(Indicate # of checks performed 22)	
Other License Fees	48
Membership Dues	6,456
Subscription & Texts	717
Public Relations	50
Human Resource Material	294
Less: Public Relations Expense	(50)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,824

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
The ARC of Illinois	98
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 98

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park Lawn Center # 0027078 Report Period Beginning: 7-1-03 Ending: 6-30-04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,457** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **124,620**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **0** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A Personal use not permitted**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Cocalas, Westberg, Mommsen, Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	1 Use	2 Make, Model & Year		3 Year Acquired	4 Cost	Current Book Depreciation	%	5 Prog. % of Depreciation	6 Straight Line Depreciation	Program % of Straight Line Depr.	7 Adjustments	8 Life in Years	9 Accumulated Depreciation
79	Medical Appts.	93 Ford Econoline	**	1993	$20,602.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$20,602.00
80	Medical Appts.	96 Mercury Sable	**	1996	$19,929.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$19,929.00
81	Medical Appts.	95 Dodge Caravan	*	1996	$34,594.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$34,594.00
83	Medical Appts.	97 Ford Club Wagon	**	1997	$27,413.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$27,413.00
84	Medical Appts.	94 Ford Econoline PA	*	1994	$35,416.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$35,416.00
85	Medical Appts.	96 Dodge Caravan	*	1996	$34,594.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$34,594.00
86	Medical Appts.	97 Dodge	*	1997	$34,995.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$34,995.00
87	Medical Appts.	96 Ford Eldorado	*	1996	$51,286.00	$0.00	0	$0.00	$0.00	$0.00	-	5	$51,286.00
88	Medical Appts.	99 Dodge Max Van	*	1999	$19,094.00	$3,659.68	8	$292.77	$3,659.68	$292.77	-	5	$19,094.00
89	Medical Appts.	00 Dodge Maxi Van	*	2000	$19,977.00	$3,995.40	8	$319.63	$3,995.40	$319.63	-	5	$15,815.13
90	Medical Appts.	01 Light Duty Ford Eld	*	2002	$44,353.00	$8,870.60	8	$709.65	$8,870.60	$709.65	-	5	$14,784.33
91	Medical Appts.	02 Mini Van Chevy Ve	*	2002	$33,545.00	$6,709.00	8	$536.72	$6,709.00	$536.72		5	$11,181.67
92	Medical Appts.	03 Ford Eldorado	*	2003	$54,404.53	$4,533.71	8	$362.70	$4,533.71	$362.70		5	$4,533.71
					$430,202.53	$27,768.39		$2,221.47	$27,768.39	$2,221.47			$319,704.13

* Owned by Park Lawn School Depreciation $2,221.47

** Owned by Park Lawn Assoc. Depreciation $0.00

$2,221.47

Due to the number of Participants transported in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.

XII. C. Vehicle Rental

	1 Use	2 Make, Model & Year	3 Monthly Lease Pymt.	Program % of Use	Program % of Monthly Lease	4 Rental Expense for this Period
21	Activities	97 Ford Club Wagon	$228.00	0.9254	$211	$2,528.40
22	Totals		$228.00		$211	$2,528.40

ɔn

Related Party Adjustment

Park Lawn Center

Lease Adjustment
Management Benefits
P/R & In Kind

ADJUSTMENT EXPLANATION
2003/2004 FY

	TOTAL	WAC I	WAC II	SUPPORTED EMPLOYMEN	ORS	CILA	126TH ST. RESIDENTI/	115TH ST. RESIDENTIAL
Total Lease	377,149	62,622	105,841	11,499	2,303	16,220	32,810	145,854
LESS: Community Lease	41,560	8,090	15,343	4,177	24	3,358	1,792	8,776
Related Organization	335,589	54,532	90,498	7,322	2,279	12,862	31,018	137,078
Interest & Depreciation Related Organization	320,510	22,631	73,865	6,796	2,388	72,879	95,436	46,515
Adjustment	(15,079)	(31,901)	(16,633)	(526)	109	60,017	64,418	(90,563)
Adjust Related Organization	320,510	22,631	73,865	6,796	2,388	72,879	95,436	46,515
Community Lease	41,560	8,090	15,343	4,177	24	3,358	1,792	8,776
Grand Total Allowable Lease	362,070	30,721	89,208	10,973	2,412	76,237	97,228	55,291
Other Adjustments								
Management Benefits	(3,536)	(378)	(556)	(70)	0	(882)	(375)	(1,275)
Public Relations	(6,203)	(66)	(6,012)	(26)	0	(33)	(16)	(50)
In Kind	0	0	0	0	0	0	0	0

	PLA	PLH
Total Interest	89,407.00	56,015.00
Total Depreciation	162,891.00	38,165.00
	252,298.00	94,180.00
PLH	94,180.00	
	346,478.00	
Fundraising	-25,968.00	
	320,510.00	

PLA Depreciation	
Bldg. Depreciation	121,692.00
Equipment Depreciation	41,199.00
	162,891.00

Mortgage Interest	88,465.00
Vehicle Interest	942
	89,407.00

Equipment	Year of Acquisition	Cost	Public Aid Life in Years	Public Aid Straight Line Depreciation	
Various Equipment	1983-1987	$34,918.53	15	$0.00	Fully Depreciated
Various Equipment	1983-1987	$49,012.19	20	$0.00	Fully Depreciated
		$83,930.72		$0.00	
EQUIPMENT 86/87					
Bedding	1987	$203.00	3	$0.00	Fully Depreciated
Camera	1987	$146.00	3	$0.00	Fully Depreciated
Rug Shampooer	1987	$1,300.00	3	$0.00	Fully Depreciated
		$1,649.00		$0.00	
EQUIPMENT 88/89					
Laz-Boy Chair	1989	$720.00	7	$0.00	Fully Depreciated
Tile Floor	1989	$1,435.00	20	$0.00	Fully Depreciated
Carpeting	1989	$1,410.00	7	$0.00	Fully Depreciated
VCR	1989	$765.00	7	$0.00	Fully Depreciated
		$4,330.00		$0.00	
EQUIPMENT 89/90					
Time Clock	1990	$1,100.00	7	$0.00	Fully Depreciated
Card Rack	1990	$75.00	10	$0.00	Fully Depreciated
Carpeting	1990	$4,931.00	9	$0.00	Fully Depreciated
		$6,106.00		$0.00	
EQUIPMENT 90/91					
Insulated Heated Cabinet	1991	$1,392.00	10	$0.00	Fully Depreciated
Mont. Ward TV	1991	$600.00	5	$0.00	Fully Depreciated
		$1,992.00		$0.00	
EQUIPMENT 91/92					
Mattresses	1991	$1,166.00	5	$0.00	Fully Depreciated
Desks (3)	1991	$507.00	5	$0.00	Fully Depreciated
Desks (3)	1991	$143.00	5	$0.00	Fully Depreciated
13 inch TV	1991	$80.00	5	$0.00	Fully Depreciated
Portable Scale	1992	$365.00	5	$0.00	Fully Depreciated
Urns - Stainless Hinges	1992	$135.00	5	$0.00	Fully Depreciated
Sand Urns (3)	1992	$101.00	5	$0.00	Fully Depreciated
Table Lamps	1992	$97.00	5	$0.00	Fully Depreciated
Reupholster Couch/Chair	1992	$1,753.00	5	$0.00	Fully Depreciated
Table (Wood)	1992	$100.00	5	$0.00	Fully Depreciated
Rattan Rocker Chair	1992	$100.00	5	$0.00	Fully Depreciated
Recliner	1992	$100.00	5	$0.00	Fully Depreciated
Walker - Aluminum	1992	$75.00	5	$0.00	Fully Depreciated
		$4,712.00		$0.00	
EQUIPMENT 92/93					
Toaster	1993	$500.00	5	$0.00	Fully Depreciated
19" TV	1993	$50.00	5	$0.00	Fully Depreciated
File Cabinets	1993	$534.00	5	$0.00	Fully Depreciated
Chairs	1993	$170.00	5	$0.00	Fully Depreciated
Vacuums	1993	$253.00	5	$0.00	Fully Depreciated
Upholstery Tool	1993	$180.00	5	$0.00	Fully Depreciated
Waste Cans	1993	$257.00	5	$0.00	Fully Depreciated
Air Compressor	1993	$270.00	5	$0.00	Fully Depreciated
Word Processor	1993	$100.00	5	$0.00	Fully Depreciated
Lockers	1993	$146.00	5	$0.00	Fully Depreciated
Mattresses (6)	1993	$450.00	5	$0.00	Fully Depreciated
Vertical Blinds	1993	$276.00	5	$0.00	Fully Depreciated
Intercom	1993	$56.00	5	$0.00	Fully Depreciated
		$3,542.00		$0.00	
EQUIPMENT 93/94					
Vertical Blinds	1994	$3,883.00	7	$0.00	Fully Depreciated
386 XS Computer	1994	$903.00	10	$0.00	Fully Depreciated
Washing Machine	1994	$434.00	5	$0.00	Fully Depreciated
Chairs/Table	1994	$588.00	5	$0.00	Fully Depreciated
Flood Light	1994	$304.00	5	$0.00	Fully Depreciated
Garbage Cans Step On	1994	$444.00	5	$0.00	Fully Depreciated
Laundry Cart	1994	$137.00	5	$0.00	Fully Depreciated
Ejector Pump	1994	$276.00	5	$0.00	Fully Depreciated
Printer	1994	$238.00	5	$0.00	Fully Depreciated
		$7,207.00		$0.00	
EQUIPMENT 94/95					
Panasonic TV's (2)	1995	$1,555.00	5	$0.00	Fully Depreciated
Sofa, Love Seat, Chairs Tables	1995	$3,395.00	10	$339.00	
Mitsubishi VCR	1995	$450.00	5	$0.00	Fully Depreciated
Lumex Bath Seat	1995	$124.00	5	$0.00	Fully Depreciated
Box Springs (31)	1995	$2,950.00	5	$0.00	Fully Depreciated
TV Cabinets (2)	1995	$538.00	5	$0.00	Fully Depreciated
Magnavox VCR	1995	$250.00	5	$0.00	Fully Depreciated
Bookcases (2)	1995	$170.00	5	$0.00	Fully Depreciated
Microwave (Quasar)	1995	$179.00	5	$0.00	Fully Depreciated
Tethers (Remote Control)	1995	$51.00	5	$0.00	Fully Depreciated
Chairs (3)	1995	$500.00	5	$0.00	Fully Depreciated
		$10,252.00		$339.00	
EQUIPMENT 95/96					
Chairs (10)	1996	$337.00	10	$34.00	
Chair	1996	$119.00	10	$12.00	
Oak Chairs	1996	$2,164.00	10	$216.00	
Lamps	1996	$404.00	10	$40.00	
Fixture	1996	$368.00	10	$36.00	
Soap Dispensers	1996	$325.00	10	$33.00	
Ice Cube Maker	1996	$2,030.00	7	$0.00	Fully Depreciated
Dryer, Gas	1996	$394.00	7	$0.00	Fully Depreciated
Wascomat Dryer	1998	$9,069.00	7	$0.00	Fully Depreciated
		$15,230.00		$375.79	
EQUIPMENT 96/97					
Dell Compute	1997	$2,295.00	10	$230.00	
Mustang Scrubber	1997	$1,370.00	10	$137.00	
Two Gliders	1997	$1,600.00	10	$160.00	
		$5,265.00		$527.00	
EQUIPMENT 97/98					
Stereo	1998	$873.00	7	$96.00	
2 Dell Computers	1998	$9,449.00	10	$945.00	
		$10,122.00		$1,041.00	
EQUIPMENT 98/99					
2 Chairs	1999	$2,599.00	10	$260.00	
EQUIPMENT 99/00					
NO NEW EQUIPMENT					
EQUIPMENT 00/01					
Hot Water Heater	2001	$4,280.00	20	$214.00	
EQUIPMENT 01/02					
NO NEW EQUIPMENT					
EQUIPMENT 02/03					
Acess Exam Table	2002	$1,354.81	7	$194.00	
EQUIPMENT 03/04					
Seat & Back Cushions	2003	$1,919.75	7	$152.00	5 months
Total PLA Equipment/Depreciation		$164,491.08		$3,100.79	
Park Lawn School & Activity Center					
EQUIPMENT 96/97					
Phone System	1996	$9,137.00	5	$0.00	Fully Depreciated
Wet Dry Vacuum	1998	$528.00	5	$0.00	Fully Depreciated
		$9,665.00		$0.00	
EQUIPMENT 01/02					
Accounting Software (Program %)	2001	$2,977.11	5	$595.42	
EQUIPMENT 02/03					
Accounting Software (Program %)	2003	$352.23	5	$70.45	
Total PLS Equipment/Depreciation		$12,994.34		$665.87	
Total Equipment Both Corporations		$177,485.42			
Total Depreciation Both Corporations				$3,766.66	

Explanation Notes:

Schedule V. Page 3 Details of Other Lines over $1,000 or with multiple type of expenses

Line 7 Column 2

Waste Removal	$28,437
Plant Security	$83
	$28,520

Line 15 Column 1

QMRP	$83,928
Res. Serv. Coor.	$26,827
Hab. Aides	$605,367
Trainer	$6,718
Psychiatrist	$4,957
	$727,797

Line 15 Reclassed $1,633 to more appropriate categories, line 20 and line 23

Line 20 Reclassed from line 15 $294 for Human Resource material

Line 23 Reclassed from line 15 $1.339 for Inservice Speaker and materials

Line 23

American Red Cross	$700	
Armstrong Medical (CPR Supplie	$29	
Career Track	$192	
Human Resources Council	$99	
Illinois Health Care Assoc.	$251	
Reliable Fire Eqipment	$60	
Southstar Services	$64	
The Arc of Illinois	$372	
Internal Board Staff Meeting supp	$214	
Inservice Speaker and Supplies	$1,339	
		$3,320

Schedule V. Page 4

Line 30 Column 5 To move depreciation of $4,396 on assets acquired with Capital Acquisition Grant from DMH which is unallowed so it won't be incl
in depreciation number that we need to tie to.
Line 36 Column 5 Unallowed Capital Acquisition Grant Depreciation identified

Line 30 Column 7 Related Party Allowable Depreciation, Public Aid Depreciation is less than Book Depreciation. Page 28-2

Building Depreciation	$26,783.00	
Equipment Depreciation	$3,101.00	
		$29,884.00

Line 35 Column 8 Community Leased equipment: Pagers $262, Copier $6,363, Time Clock $44, PACE $2,107

Schedule VII. Part B

Park Lawn Association, Inc.			
Building Rental not allowed			($132,911)
Equipment Rental not allowed			($4,166)
PLS Bldg. Interest Allowed $5,170.34 X .079		$409	
Vehicle Interest Allowed $942 X 8.0%		$75	
			$484
Depreciation Allowed			
Building	$26,783		
Equipment	$3,101		
Total Depreciation Allowed *			$29,884

* Based on Public Aid allowable Depreciation Book Depreciation on building is $2,400 higher than Public Aid allowable depreciation

Total Related Party Adjustment Detailed on Page 5A line 49 ($106,709.00)

Schedule IX. Page 9

Line 15 $484 is the allowable portion of program interest, see page 5A Line 2

Schedule XI. Part D

Line 46 Column 5 Includes only the program portion of depreciation costs on vehicles.
Due to the number of participants in all Park Lawn Programs and varied routed, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis.

Schedule XII Part C Page 14

Due to the number of participants in all Park Lawn Programs and varied routes, Park Lawn is unable to assign one vehicle to any one location, so costs are assigned on a percentage of use basis. These vehicle lease costs are only program portion and are for activities.
A detailed schedule of proration is on Page 25.

Schedule XIII. B Page 15

Line 5 Column 4 Wages are included on page 20 line 33.

Schedule XVIII. Page 19 Line 41 and 43

Unallowed Depreciation on Capital Acquisition Grant of $4,396

Schdeule XVIII. Page 20 Line 33

Drivers	$17,084
Trainer	$6,718
	$23,802

Schedule XX. Page 23

Question 12 Allocated on basis of hours worked per department

Question 15 No Employee meals are served